

Results of 2000 Immunization Assessments

The Massachusetts Immunization Program (MIP) has been conducting immunization assessments in pediatric provider offices and community health centers since 1993. A site visit consists of an assessment of Vaccines for Children (VFC) compliance, proper storage and handling of vaccines, and immunization levels of 2-year-olds in the practice.

In 2000, the MIP adopted a new methodology, lot quality assurance (LQA), whereby a small number of charts are assessed at each site, and a site passes or fails the assessment based on a predetermined threshold. This methodology enabled the MIP to increase the number of site visits from 74 in 1990-1999, to 262 in 2000. Of the 262 sites assessed in 2000, 213 (81%) passed, and 49 (19%) did not meet the standard. The MIP intends to conduct an immunization assessment at every pediatric provider site in Massachusetts by 2004. In 2001, the MIP will conduct at least 370 immunization assessments. Each practice, regardless of their performance, will receive a quality assurance feedback session from an MIP staff member on the day of the assessment. Two recent initiatives will strengthen the quality assurance portion of the immunization assessment. First, the MIP revised the data collection and analysis algorithm. It now enables quick and easy identification of barriers to immunization, as well as strategies that a practice can initiate to improve and maintain immunization levels. Second, a document entitled, *Immunization Best Practices*, summarizes evidence-based, successful strategies identified in the medical literature for improving and maintaining immunization levels. The *Immunization Best Practices* document focuses on the importance of decreasing missed opportunities for immunization, conducting reminder/recall, and accurate documentation as important ways to improve immunization levels. It also encourages providers to designate an "immunization champion"; to educate themselves, their staff and their patients; and to adhere to minimum interval and ages for antigens.

Copies of the *Immunization Best Practices* document, other immunization materials, and further information about the MIP's immunization assessment process can be obtained from the MIP by calling 617-983-6800 or toll-free 888-658-2850. It is also available on the MIP web site, www.state.ma.us/dph.

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Hospital Interpreter Services Update: Regulations and Best Practices

On June 26, 2001, the Public Health Council approved final Massachusetts Department of Public Health (MDPH) regulations governing the provision of competent interpreter services in Emergency Departments of Massachusetts Hospitals (105 CMR 130.1100 et Seq.). The regulations follow enactment of Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Services". As noted in the Division of Health Care Quality circular letter (DHCQ 01-07-414), the regulations have the following features:

- Hospitals must designate a coordinator of interpreter services with overall responsibility for the operation of the program.
- Hospitals must provide notices and signage informing persons coming to the emergency department of their right to interpreter services.

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Epidemiology

Public Health Risks of Keeping Wildlife as Pets

Recently the Massachusetts Department of Public Health (MDPH) has been involved in several situations involving individuals keeping wild animals, such as baby raccoons, opossums or woodchucks, as family pets. Often, these animals become ill and are submitted to the State Laboratory Institute for rabies testing. If one of these animals tests positive for rabies, any exposed individual (in some cases, hundreds of people) must receive rabies post exposure prophylaxis. Post exposure prophylaxis entails a series of 5 shots of vaccine and one dose of immune globulin over a period of 28 days.

Young animals often appear cute, harmless and tame. But, as most people discover, wild animals are not domesticated animals, not as civilized, and will often revert to aggressive and destructive behavior as they mature. Often, these animals become a health risk to humans. It is important to teach children, in particular, to avoid contact with wildlife.

It is against both state and federal law to possess wild birds or mammals without an appropriate permit and there are no permits available for keeping any wildlife species as pets. These laws are in place to protect humans from the aggressiveness of undomesticated wildlife and possible health risks, and to protect the animals from abuse or improper care.

Wildlife can carry serious and sometimes fatal diseases that can be passed to humans, especially children. Even infant animals can carry viruses, bacteria, and parasites that can affect humans. An animal does not have to appear ill to be a carrier of the infectious agents that cause rabies, tularemia (rabbit fever), psittacosis (parrot fever) and plague.

Rabies is often the public health matter of most concern in wildlife. Without proper vaccination before the onset of symptoms, rabies is 100% fatal. In wildlife, the rabies virus can be passed from mother to offspring and in some cases the mother's demise with rabies may be the reason the young were orphaned. The rabies virus is usually transmitted to humans through an infectious animal's saliva introduced by a bite. The virus can be transmitted to humans through breaks in the skin, such as abrasions or cuts, or through a mucous membrane (eyes, nose and mouth). Bites, scratches, and licking by a rabid animal, or not washing one's hands after exposure to the saliva of a rabid animal and then touching one's eyes, nose or mouth are all potential routes of rabies transmission.

Raccoons can be infected with a particular type of parasitic

roundworm that can cause serious illness in humans. An adult worm lays eggs that are shed in the raccoon's feces. These eggs can be very difficult to destroy. Close contact with raccoons and their excrement puts people at risk.

If you already have a wild animal as a pet, please contact your local or state health department to discuss the human risks. Since there is no approved rabies vaccine for wildlife and the incubation period of the virus in wildlife is unknown, it is likely that testing the animal will be recommended. If you observe a hurt or abandoned animal, avoid any contact and call your local animal control officer or the nearest wildlife rehabilitator (http://www.state.ma.us/dfwele/dfw/Dfw_rehab.htm). There are very few veterinarians who will treat wild animals, especially wildlife held without a permit.

Hepatitis C Hotline

In early May of 2001, the MDPH-funded Hepatitis C Hotline began taking calls. This service can answer questions about viral hepatitis, counsel people who are infected with or affected by hepatitis C, and provide referrals to related programs. The hotline's hours of operation are from 9am to 9pm, Monday through Friday and from 10am to 2pm on Saturdays. Staff are available to answer calls in English and Spanish at all times, Portuguese Mon - Fri, and in other languages, as available. The toll-free number to call is 1-888-443-HepC (4372).

New Lyme Disease Website!

In April 2001, the Massachusetts Department of Public Health (MDPH) posted a new website <www.state.ma.us/dph/cdc/epii/lyme/lymehp.htm> with information on Lyme disease for health care providers and the general public. The site is divided into six sections including Lyme disease surveillance statistics for Massachusetts and the United States, clinical information for health care providers, Lyme disease vaccine, the MDPH Lyme disease surveillance program, MDPH Lyme disease educational materials for the general public, and online Lyme disease resources. In the future, the site will be expanded to contain information on other tick-borne diseases. If you have any comments on the site, please call the MDPH Division of Epidemiology and Immunization at 617-983-6800.

Men Who Have Sex with Men, and Syphilis Elimination in Massachusetts

The decline of syphilis among men who have sex with men (MSM) was one of the public health success stories of the 1990s. In Massachusetts, MSM accounted for approximately 50% of the infectious syphilis that was reported in the late 1970s and early 1980s. With community mobilization and public information and educational efforts aimed specifically at HIV/AIDS, rates of infectious syphilis declined precipitously. By the mid-1990s, less than 1% of infectious syphilis was reported in MSM. This decline occurred at the same time that surveillance for STD in general, and syphilis in particular, improved.

However, the situation changed in 1999. Although reported infectious syphilis cases were at the lowest level since surveillance began in 1918, six of the 97 cases were in MSM (8%). In 2000, there was an increase in the number of reported syphilis cases to 139, of which 34 were in MSM (25%). In the first six months of 2001, there have been 49 cases of infectious syphilis reported, with 15 (31%) in MSM. While absolute numbers of syphilis cases remains low, the proportion of cases in MSM continues to increase.

Syphilis among MSM could foreshadow an increase of HIV infection. Many of the reported syphilis cases relate to seeking partners in venues, such as Internet chat rooms, bathhouses, bars, parties and social gatherings. The Massachusetts Department of Public Health has been working with community groups to produce and distribute appropriate health education materials and messages to those MSM at greater risk.

- The HIV/AIDS Bureau of MDPH and the AIDS Action Committee have brought to bear resources and have provided syphilis prevention posters for MSM bars around the state.
- A "Syphilis Alert" was sent to clinicians statewide.
- Six regional "Syphilis Elimination Forums" were held this past spring in order to generate interest in the issue and obtain input.
- Communication with the other states and cities has helped all programs to learn from experience of the others.
- A statewide Public Health Advisory Group to Eliminate Syphilis is being formed.
- The Region I STD/HIV Prevention Training Center held a telephone conference on syphilis elimination.
- AIDS Action Committee assisted in the distribu-

tion of syphilis prevention brochures during the Gay Pride celebrations in Boston.

- Men of Color Against AIDS (MOCAA) is assisting in developing and coordinating outreach.
- The Latino Health Institute has distributed materials at a Latino MSM Retreat that took place in Provincetown.
- A surveillance project is underway, in conjunction with the Fenway Community Health to help improve intervention strategies.



APIC-New England Marks 25th Anniversary

The Association of Professionals in Infection Control and Epidemiology - New England Chapter (APIC-NE) is celebrating its 25th year as the first chapter of the national APIC, founded on January 1, 1976. Organized by twelve infection control nurses in 1975, the chapter now has approximately 500 members across New England. It was the model chapter for the 11,000 member national organization that now includes 112 active chapters.

APIC-NE members have been at the forefront of infection control practice on regional, national and international levels. The chapter has been instrumental in the evolution and development of the profession of infection control. Working closely with local and state public health departments, as well as with the Centers for Disease Control and Prevention, APIC members and APIC-NE have taken a leadership role in disease surveillance and control in the community, as well as in the facilities in which most members are based. Close working relationships and day-to-day communication between infection control professionals and health departments have been of critical value to effective communicable disease control. APIC-NE and the community of infection control professionals it represents are at the core of a network of knowledgeable and committed specialists across the communities of New England.

Public health departments at the local and state level recognize the critical role that the members of APIC-NE play in communicable disease control and improving health

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Immunization

Vaccine Quality Control at Provider Sites

Massachusetts is one of only eleven universal vaccine distribution states, providing all of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP) recommended childhood vaccines, free-of-charge, to all children through 18 years of age, at public and private provider sites. Our state's consistently high immunization coverage levels are due, in part, to universal childhood vaccine distribution.

Since 1996, the Massachusetts Immunization Program (MIP) has expanded its quality control program to ensure that vaccines are being handled and stored appropriately. This includes disseminating temperature logs, refrigerator magnets with the proper storage temperature listed, informational flyers, regional trainings statewide (with approved CEU and CME credit hours), and vaccine management assessments. During 2001, MIP staff will conduct vaccine management assessments at more than 500 sites, including all local vaccine depots and over 350 private pediatric provider sites.

The vaccine management assessment is designed to be educational for provider site staff. It is usually done in conjunction with an immunization assessment site visit, which reviews the immunization levels of a sample of the two-year-old's records. It includes a review of vaccine administration documentation, use of Vaccine Information Statements (VIS), accountability for the vaccine on the Vaccine Usage Report (bubble sheet) and Vaccine Order Form, and appropriate storage and handling of vaccines.

The most common vaccine management deficiency is refrigerated vaccine that has not been stored within the proper temperature range (2°C to 8°C, or 35°F to 46°F). Over the past three years, approximately 9% of assessed sites stored vaccines at temperatures outside the recommended range. The improperly stored vaccines may become damaged and not have the necessary potency to protect from disease. Revaccination had to be considered.

Providers are randomly selected for an immunization assessment/vaccine management site visit, but the MIP would welcome the opportunity to visit any site and educate staff (perhaps at a staff meeting) on the proper storage and handling of vaccines, and the risks associated with improper storage. If you are interested, please contact the MIP/Vaccine Management Unit at (617) 983-6828 to arrange a convenient time.

2001-2002 Influenza Vaccine Availability

The Massachusetts Immunization Program (MIP) is planning to distribute 740,000 doses of influenza vaccine for the 2001-2002 season; which is 65,000 more doses than last season. However, availability of influenza vaccine will be delayed again. The MIP will be receiving influenza vaccine in multiple shipments. The first shipment (approximately 25% of total purchase) is anticipated by mid/late September. The MIP has been notified that it will most likely not receive the bulk of vaccine until November. Therefore, providers will be receiving their state-supplied influenza vaccine incrementally. Providers will need to prioritize available vaccine to ensure that it is administered first to those who are at greatest risk.

Check the MDPH web site www.state.ma.us/dph for updated information on the availability of influenza vaccine.

No Shortage of Td Vaccine in Massachusetts

While there is a serious shortage of tetanus-diphtheria (Td) vaccine elsewhere in the U.S. that is expected to last through 2001, there is no shortage of Td vaccine in Massachusetts because the Massachusetts Biologic Laboratories (University of Massachusetts Medical School) manufacture Td vaccine for use in Massachusetts. Providers should continue to give routine Td boosters to adolescents and adults.

In addition, students entering 7th grade or college in Massachusetts are still required to have a Td booster. Massachusetts residents who receive medical care in bordering states are advised to seek Td vaccination at urgent care centers or at other providers within Massachusetts. Schools and colleges in Massachusetts may wish to provide Td vaccination clinics for out of state students who are unable to be vaccinated prior to the start of the school year.

If you are currently enrolled in the Massachusetts Immunization Program (MIP), you may order free state-supplied Td vaccine from your local vaccine distributor. Sites interested in enrolling in the MIP should call the MIP Vaccine Management Unit at 617-983-6828. If you have any questions regarding Td vaccine, please call the MIP at (617) 983-6800 or toll free at (888) 658-2850.

TB Exposure in a Day-care Setting

A 25 year-old woman with symptoms of cough and fever was diagnosed and treated for pneumonia at a local emergency department (ED). Three months later, the young woman again presented to the ED with fever, weight loss and a productive cough of 3 months duration. At this time, she was admitted to the hospital and subsequent diagnostic tests supported a diagnosis of active, infectious, pulmonary tuberculosis.

Because of the infectious nature of this case, a contact investigation was undertaken. An interview was conducted to determine the case's daily routine at home, socially and at work. The local health department began the process of identifying those people who had spent significant amounts of time with the case and had the potential of being infected due to the exposure. The young woman worked as a teacher's aide at a large day-care center, and rotated through various classrooms on a regular basis. An intensive investigation was conducted at the day-care center.

Public health nurses from the local health department and the TB Division met with administrators of the day-care center to discuss the exposure and to begin screening those children and teachers potentially exposed to the case. This was a high profile and sensitive situation as it involved a day care center with approximately 500 children under the age of five years. This investigation required expertise, collaboration and communication among agencies and the public, and numerous resources to ensure that the children and adults who were exposed to the case received timely and appropriate evaluations. Over two hundred sixty (260) children were identified as contacts. Notices were sent to the parents and/or guardians, record reviews were conducted to obtain past tuberculin skin test results (TSTs) and educational sessions were held in conjunction with the initial screenings of the children.

Are there special precautions that must be considered when young children have been exposed to TB?

Children under five years of age, regardless of initial TST results, must have a chest x-ray to rule out active disease. If the initial TST is positive and the chest x-ray is normal, the children are placed on INH therapy for 9 months. If the initial TST is negative and the chest x-ray is normal, treat-

ment (window prophylaxis) for "possible latent TB infection" is recommended until the results of a follow-up TST, 8-12 weeks post-exposure are known. If the repeat (follow-up TST) is negative, then the treatment is discontinued. Abnormal chest x-rays, regardless of TST status, require further evaluation.

Why treat children who have an initial negative TST? Children (and adults) who have recently been exposed to TB may have a negative reaction to the TST if tested less than 12 weeks since their last exposure, even if they are truly infected. This is because it can take up to 12 weeks for the immune system to respond. Children are treated more aggressively because they have a higher risk of progressing to disease once infected and are more likely to have serious complications if they develop disease.



Remember

Often we receive many CD Updates returned to our office. Report any name or address changes to your Communicable Disease Update subscription to our office. Call or email Jacki Dooley at (617) 983-6559 or jacqueline.dooley@state.ma.us to keep your subscriptions coming to you!

APIC 25th Anniversary continued from page three

outcomes in individuals and the community. It is impossible to imagine how we would have achieved the progress made in the surveillance and control of infection in the past 25 years without the support and participation of the professional infection control community. APIC-NE has also been a strong advocate for public health. The Massachusetts Department of Public Health salutes APIC-NE on completion of its first 25 years and looks forward to continued and enhanced collaboration as we face the challenges of the future.

For more information about APIC-NE and its activities, visit its website at www.apicne.org.

Refugee & Immigrant Health

Refugees in Central Massachusetts

Central Massachusetts was the destination for over 550 refugees during the four-year period of July 1, 1997 through June 30, 2001. While this number represents less than 6% of all resettlement in the Commonwealth, it is nonetheless a significant commitment to welcoming newcomers. Refugees from 23 different countries were resettled in the region, three-quarters from one of three primary countries: 33% (185 persons) from the former Yugoslavia, including Bosnia and Kosovo, 22% (124 persons) from Vietnam, and 20% (121 persons) from Liberia. Previous to 1997, most refugees resettled in this area were from Southeast Asia.

Nineteen cities and towns in the Central region were the initial destination for newly arrived refugees. Worcester was the new home for the majority (71%). With the exception of Shrewsbury, the 18 remaining towns received fewer than ten refugees each over this four-year period.

Three large voluntary agencies or VOLAGs - the agencies responsible for resettling refugees - have affiliate offices in Worcester. They are the United States Catholic Conference (Catholic Charities of Worcester), the Hebrew Immigrant Aid Society (Worcester Jewish Federation) and the International Rescue Committee. While Lutheran Social Services provides a range of refugee services through their office in Worcester, their West Springfield office manages resettlement in this area.

Among the many responsibilities of the VOLAG caseworker is making arrangements for the initial health assessment. The assessment serves to introduce the refugee to the U.S. health care system and to identify conditions that require follow-up, either through the public health system or primary care. Great Brook Valley Health Center in Worcester has the refugee health assessment contract for the Central region. The health center has successfully evaluated 97% of the refugees referred for services.

The Refugee and Immigrant Health Program has five staff based in the Tewksbury Regional Office to cover both the Central and Northeast regions. As regional coordinator, Bich Ngoc Vu supervises community outreach educators and works to ensure that refugees receive appropriate health services related to initial health assessment, special medical needs, tuberculosis testing and treatment, and primary care. She works closely with local health departments and health care providers. Four bilingual, bicultural outreach educators function as resources to both refugees and providers. Hoang Kim Tran and Astrit Seiti work primarily in Worcester with Vietnamese and Albanian-speaking communities, respectively.

They also work with the Worcester Health Department and the Getchell-Ward Tuberculosis Clinic at Family Health and Social Services. Sovannary Lak and Toy Vongpheth work primarily in the Merrimack Valley with Cambodians and Lao, respectively. They are also able to provide support, as needed, to providers and refugees in the Central region.

Persons interested in additional information may contact Bich Ngoc Vu at 978-851-7261.

Visit Us On The Web!

Electronic copies of Communicable Disease Update can be found on the world wide web at www.state.ma.us/dph/cdc/update/comnews.htm. Current and past issues are available at the above web address.



Interpreter Regulations continued from page one

- Hospitals must conduct an annual language needs assessment in their service areas.
- Hospitals must assure that interpreters have received appropriate training in the skills and ethics of interpreting.
- Hospitals must refrain from encouraging the use of family members for interpreting, and are prohibited from using minor children.

A document, Best Practice Recommendations for Hospital-Based Interpreter Services, was developed to accompany the regulations and to serve as a resource to hospitals. The document was developed by MDPH, in consultation with a broad array of organizations active in promoting the provision of competent interpreter services. The major purpose of the document is to identify and describe the components of an optimal interpreter services program for hospitals - both for emergency services (in compliance with the regulations) and for other hospital-based clinical services.

The regulations and best practice recommendations can be found on the MDPH website www.state.ma.us/dph/bhqm/licregs.htm.

Questions about the regulations should be directed to Gail Palmeri, Manager of the Hospital Licensure Program, at (617) 753-8000. Additional information on the best practices document is available from Brunilda Torres, Director of the Office of Minority Health, at (617) 624-5272.

Harvard Hosts a Unique Summer Program in Global TB Control Leadership

During July and August of this year, Harvard Medical School's Program in Infectious Diseases and Social Change (Department of Social Medicine) hosted a unique educational program entitled, "Global Health Leaders Fellowship" or GHLF. The program brought to Boston eight high-level physicians and scientists involved in international tuberculosis control, four from Russia, and four from Peru, two countries where Partners in Health (PIH), a charitable non-governmental organization based in Boston, is working to control multidrug-resistant (MDR) TB. These pioneering efforts to control MDR-TB in resource-limited countries are made possible through funding from the Bill and Melinda Gates Foundation and other sources. Joining the Peruvian and Russian leaders in the summer program were four medical residents from the Brigham and Women's Hospital (BWH), who are committed to working in international health.

It was a busy two months for the international visitors, with little time for sightseeing. Their days began with intensive courses in biostatistics and epidemiology - part of the annual summer "Clinical Effectiveness" program at the Harvard School of Public Health. A course requirement was the design of a clinical research project using the principles learned in class. Whereas the projects that most of the summer students planned will never progress beyond academic exercises, those planned by the GHLF fellows will actually be carried out in their home countries. Each project is to be joined by a BWH resident. The afternoons were filled with discussions specific to international TB control and planning research projects. In addition to local experts from Harvard, Boston University School of Public Health and Massachusetts Department of Public Health, research mentors and discussants came from the Centers for Disease Control in Atlanta. GHLF fellows toured the MDPH Mycobacteriology Reference Laboratory (also a WHO-certified international reference laboratory) and the Lemuel Shattuck Hospital, an MDPH facility with specialized capacity and expertise for treating MDR-TB and other difficult cases.

The fellows were a heterogeneous group, with backgrounds that included pulmonary and infectious diseases, as might be expected, but also psychiatry and medical anthropology. Anyone who works in TB control understands that barriers to successful control go beyond medical treatment and include behavioral and cultural issues. Partners in Health stresses that global economic inequities are the main obstacle to better health among the poor. Paul Farmer's *Infec-*

tions and Inequalities and Jim Kim's *Dying for Growth* are two recent books by the co-founders of PIH that discuss the fundamental problems that this summer course addressed.

Northeast Regional Clinical Services Highlight Tuberculosis Surveillance Area (TSA 3)

TSA Nurse: Nancy J. Taylor-Flynn, R.N., B.S.N.
Administrative Assistant: Constance Parke

In 2000 there were 285 verified incident cases of tuberculosis in Massachusetts, of which 48 were in people who resided in the Northeast Region. Higher risk communities in TSA 3 include Lawrence, Lowell, Lynn and Malden. The TB Division funds 26 TB clinics throughout the state, four of which are located in TSA 3 (Lawrence, Lowell, Malden, Salem). This Update issue will highlight one, the North Shore Pulmonary Clinic (NSPC) located at the Salem Hospital in Salem.

This clinic serves a large area consisting of the following cities and towns: Amesbury, Beverly, Danvers, Essex, Gloucester, Hamilton, Ipswich, Lynn, Lynnfield, Manchester By the Sea, Marblehead, Middleton, Nahant, Newbury, Peabody, Rockport, Rowley, Salem, Salisbury, Saugus, Swampscott, Topsfield, Wenham and West Newbury. Christine Blaski, MD, (Director), Peter Kirkpatrick, MD, Faysal Hasan, MD, Neil Shore, MD, Peter Thielhelm, MD and Alexander White, MD provide medical coverage.

Karolyn Jernigan, RN, current Clinic Manager, recently accepted a position in the California State TB Program. Shean Marley, RN Clinical Coordinator of Outreach Education Services will assume clinic management. Angela McCarty, RN provides nursing services at the clinic site. Mary Jane Thomas provides secretarial services.

Clinic services are provided twice weekly on Monday and Wednesday from 9:00 AM to 4:00 PM. Late afternoon clinic hours at NSPC and Lynn Health Department are an added benefit. Multidisciplinary patient care conferences and quarterly meetings are held on a regular basis. Transportation via shuttle bus from Lynn City Hall is provided on Mondays, and public transportation or taxi vouchers are provided as needed.

The clinic is accessible to the diverse at-risk populations it serves, with interpreter services provided.

Save the dates

2001 Satellite Courses

All Satellite courses will be held at the UMass Medical School Campus at the State Laboratory Institute in Jamaica Plain, MA. Satellite courses may be offered at multiple sites throughout the state. Contact Walt Lasota at (617) 983-6834 or walter.lasota@state.ma.us for more information on the satellite courses.

Satellite courses scheduled for Fall 2001:

Vaccinations for International Travel: December 13, 2001 from noon to 3:30 PM EST. Sponsored by CDC/PHTN.

Antibiotics: Yesterday, Today & Tomorrow

October 17, 2001 from 8:00 AM to 4:00 PM at the Burlington Marriott in Burlington, MA. Contact the Northeast Office of National Laboratory Training Network at (617) 983-6285 for more information.

Conference on Refugee Women's Health

October 29, 2001 at the Massachusetts Medical Society. For more information, contact the Refugee and Immigrant Health Program at (617) 983-6590.



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